Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WEST HOUSTON SURGICARE
970 CAMPBELL ROAD
HOUSTON TX 77024

Respondent Name

WAL MART ASSOCIATES INC

Carrier's Austin Representative Box

Box Number 53

MFDR Tracking Number

M4-11-0612-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated October 29, 2010: "Follow medicine invoice + 10% with 153% procedures."

Requestor's Supplemental Position Summary dated February 24, 2011: "(3) other items used to complete surgery – invoice implants. This is where shortage is. For Resolution."

Amount in Dispute: $316.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**DOCUMENTED IMPLANTS CORRECTLY PAID PROVIDER COST + 10%. PLEASE REFER TO PAGE 2 OF OPERATIVE REPORT; THE FOLLOWING IMPLANTS ARE CLEARLY DOCUMENTED:**

- BioCorkscrews X2 $690
- PushLocks X2 $790
- TOTAL COST $1480 + 10% = $1628

PROVIDER HAS INCORRECTLY REQUESTED SEPARTE PAYMENT FOR NON-IMPLANTABLES; THESE ITEMS WERE CORRECTLY DENIED FOR SEPARTE IMPLANT REIMBURSEMENT:

- MULTIFIRE SCORPION NEEDLE – COST $170
  - See product descriptor per provider invoice: This is a NEEDLE (for independently passing 2 FiberWire sutures without removal). NOT IMPLANTABLE.
- DOUBLECUT 4.0 MM X 13 CM – COST $59
  - Per product name, this is an instrument for CUTTING. Per Anthrex website, this is ideal blade for efficient general soft tissue resection & fine sculpting of articular cartridge. NOT IMPLANTABLE
- OVAL BURR 12 FLUTE 5.5 MM x 13 3 M – COST $59
  - Per product name, this is a BURR. Per Anthrex website, this is utilized for resection bone & soft tissue. NOT IMPLANTABLE

TOTAL COST OF THESE INSTRUMENTS = $288 + 10% = $316.80. THIS ACCOUNTS EXACTLY FOR PROVIDER'S ADDTL PAYMENT REQUESTED, WHICH IS DETERMINED AS NON-COMPENSABLE.

Response Submitted by: Hoffman Kelley on behalf of Wal-Mart Associates, Inc., 5316 hwy. 290 West, Suite 360, Austin, TX 78735.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 11, 2010	HCPCS code C1713	$316.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated July 12, 2010
   - W1-Workers Compensation state fee schedule adjustment.
   - 11-The recommended allowance for the supply was based on the attached invoice.
   - 13-An additional allowance has been recommended for implants/prosthetics.

   Explanation of benefits dated October 9, 2010
   - W1-Workers Compensation state fee schedule adjustment.
   - 11-The recommended allowance for the supply was based on the attached invoice.
   - 13-An additional allowance has been recommended for implants/prosthetics.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Did the requestor support position that additional reimbursement is due for HCPCS code C1713? Is the requestor entitled to reimbursement?

Findings

1. The requestor states in supplemental position summary that "(3) other items used to complete surgery – invoice implants. This is where shortage is. For Resolution."

   The requestor billed HCPCS code C1713 for the disputed implantables.

   HCPCS code C1713 is defined as "Anchor/screw for opposing bone-to-bone or soft tissue-to-bone (implantable)."

   The respondent states in the position summary that "**PROVIDER HAS INCORRECTLY REQUESTED SEPARTE PAYMENT FOR NON-IMPLANTABLES; THESE ITEMS WERE CORRECTLY DENIED FOR SEPARTE IMPLANT REIMBURSEMENT**."

   28 Texas Administrative Code §134.402(b)(5) states "'Implantable' means an object or device that is surgically:
   (A) implanted,
   (B) embedded,
   (C) inserted,
   (D) or otherwise applied, and
   (E) related equipment necessary to operate, program, and recharge the implantable."

   A review of the submitted documentation indicates that the requestor is seeking reimbursement for the following: Multifire Scorpion Needle, Doublecut 4.0 MM X 13 CM, and Oval Burr 12 Fluete 5.5MM X 13 CM.

The submitted Operative report supports the following under the heading “IMPLANTS” that “Arthrex 5.5 Bio-Corkscrew X2 with 2 lateral PushLocks.”

The Intra-Operative Record states under the Implants heading that BioComposite PushLock X 2 and BioComposite Corkscrew X 2 was used.

The Division concludes that the requestor has not supported that the Multifire Scorpion Needle, Doublecut 4.0 MM X 13 CM, and Oval Burr 12 Fluete 5.5MM X 13 CM is an implantable as defined by 28 Texas Administrative Code §134.402(b)(5). The Division further concludes that the documentation does not support the requestor’s position that these items were implantables. As a result, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		2/2/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.